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LOCAL DIRECTORY

Medical Society Meetings

MARYLAND

NOTE.—Secretaries are requested to advise us promptly of the election of new officers in their respective Societies, that due announcement may be made in the JOURNAL.

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DISEASES OF THE RECTUM.*

By Harold Edmund Dunne, M.D.,
Washington, D. C.

Mr. President, Members of the
Prince George's County Medical Society:

At the request of your secretary, Dr. McMillan, I have the honor to read to you today a short paper on Diseases of the Rectum. I have chosen for a theme the examination of patients and the diagnosis of conditions. It is my desire to give you something of interest and real practical value in this much-neglected line of thought.

Very few of the medical colleges of the country give a separate or special course of instruction on the subject of rectal diseases. A few lectures from the Chair of Surgery are usually all that the majority of medical students receive. "To tie off a pile and insert a grooved director through a fistulous tract, severing the intervening tissues with one sweep of the knife" is frequently about all students remember of this subject. This is unfortunate for the doctor and more so for suffering humanity, but a Godsend to the charlatan and the long array of pile cures that meet us through the advertising pages of our daily literature.

Most physicians have neither the time nor special knowledge and experience necessary to successfully treat diseases of the rectum. The demands on the general practitioner are so numerous and varied that it is difficult to keep regular office appointments with patients of this class. Positive punctuality on the part of both physician and patient is one of the essentials to the successful outcome of these cases, essential to the physician so that he can treat the patient sufficiently often and essential to the patient because if disappointed many times by the physician, owing to emergency or confinement cases, he loses interest and ceases to call. Nevertheless, from the standpoint of examination and diagnosis, the general practitioner, in many instances, can render valuable assistance to the rectal sufferer by a careful examination and an accurate diagnosis. By such means the farseeing physician will

*Read, by invitation, before the Prince George County Medical Society of Maryland, October 9, 1915.

retain the confidence of these patients and prevent them from drifting into the hands of quacks or patent medicine promoters.

We now come to the technique of examination. First of all, let me say that if the examination is going to be painful and nerve-racking to the patient it better be deferred. One experience of this kind is often the last, and the patient either continues to endure or seeks advice elsewhere. Posture is another important factor. It is better not to put your patients, especially women, in the knee-chest position. It is humiliating and unnecessary in the great majority of cases. The Sims position answers all requirements from the standpoint of examiner, and is eminently more satisfactory to the patient. The preliminary to all examination technique should be, of course, a complete case history. Following this, external inspection of the anal and peri-anal regions is made. Here one may diagnosticate hypertrophied cutaneous skin folds (the so-called external piles); the thickened, macerated condition of the peri-anal skin will suggest pruritus, with its many causes; condylomata may be in evidence; the openings of a fistulous tract, a thrombotic hemorrhoid (which has been humorously termed rectal apoplexy); scars or keloid formations showing the handwork of some other protologic artist may greet your eyes, and I might say that I have had the fortune or misfortune to see some wonderful pictures. Eversions of the rectal mucosa, prolapsus recti, fissures, protruding internal hemorrhoids, with or without peri-anal edema; an occasional polypus held in the grasp of the sphincter, dilatation of the peri-anal veins; tubercular ulceration, superficial, subtegumentary and ischio-rectal abscesses; a possible sinus at the sacro-coccygeal articulation. These are the principal conditions that can be made out by external inspection. I might add that the presence of an abundance of long, fine, silky hair about the anus is significant of a serious constitutional or malignant condition. The absence of the puckered or wrinkled folds of the anal skin, in other words, a smooth, rather patulous anus, is frequently the very first symptom of locomotor ataxia.

External palpation will then elicit the presence or absence of indurations, and right here let me say, gentlemen, "watchful waiting" is a poor policy. It is more, it is a dangerous policy to follow when dealing with abscess in this region of the body. Fluctuation of pus, except in the most superficial infections, is rarely obtained in this portion of the human anatomy. The loose cellular tissues, the fat accumulations and tough integument make rapid extension of pus, and consequently extension of infection, or complications, the usual rule. Early incision, with due regard for anatomical relationships, thorough drainage and subsequent dressings, is the rational treatment of these cases.

Contrary to many surgical authorities, I will say that abscesses in this region, properly opened and properly dressed, do not result in fistula. Furthermore, where the integrity of the sphincter muscles is not involved, the severance of these muscles in the treatment of abscess is seldom necessary. External palpation will often

show the direction of a fistulous tract, and the condition of the external sphincter, whether contracted, quiescent or patulous.

Next we come to the internal examination of the rectum, and right here let me say it is never advisable to use a bivalve speculum unless your patient is under a general anesthetic; that is, if you want to retain the respect of your patient and the continuance of your daily administrations. The mechanism of a painless rectal examination with a speculum lies in the displacement of the sphincter in all directions equally at the same time, and this is best done with one of the various tubular specula or proctoscopes on the market. Internal hemorrhoids, polypi, the internal openings of fistulae, acute or chronic inflammatory conditions of the rectal mucosa, foreign bodies, degrees of prolapsus, stricture; abnormal growths, malignant and benign; the presence of free pus or blood within the rectum, chancre and capillary hemorrhoids can be seen and verified.

As a preliminary to all instrumental examination of the rectum, a careful exploration with the lubricated finger is an absolute rule. Internal hemorrhoids that have undergone fibrous changes can be felt, openings of fistulae, polypi, foreign bodies, strictures within reach, sphincteric irritability and hypertrophy, ballooning of the rectal cavity, fecal impaction, abnormal growths, prostatic enlargement, displaced uteri and other gynecological conditions, a deformed or sensitive coccyx, submucous collections of pus, pelvirectal and retro-rectal abscesses can all be determined by the educated finger.

By means of the air dilating type of proctoscope, electrically illuminated, the rectal valves, ampulla and the sigmoid cavity can be inspected and treated. The proctoscopic limit of examination in the normal subject is about the apex of the sigmoid.

I am very much opposed to the various colonoscopes now in the market. They are both dangerous and unnecessary. If a patient's sigmoid or colon is diseased it is unsafe to insert such an affair, as puncture of the intestine is an easy matter in such cases. Peritonitis—a laparotomy or death, or all of these—may be the result of such a hazardous procedure. On the other hand, if the sigmoid and colon are in a healthy, resistant condition there is no need for the insertion of this formidable instrument. Therefore, I see no use for it, and recommend the discontinuance of its manufacture, not only as a measure of safety to present and future generations, but as an economy of the recent graduate's meagre supply of outfit money.

There is another rectal fallacy that I would like to mention this afternoon, and that is the much-used rectal tube. It is impossible to pass a rubber rectal tube into the colon of a normal human being. After its apparently successful introduction, insert a finger alongside of it and you will find it nicely coiled up like a snake in the rectal pouch. Radiographs have demonstrated the failure of the rectal tube in many experiments. There is an especially pernicious tube that has recently appeared on the market. This is reinforced

with metal like the tubing of an auto horn. With a weapon of this kind a tremendous amount of damage can be done at one end if there is a specially energetic nurse at the other who is going to give it "high" at any cost.

By simple gravity, the douche bag low down, an ordinary rectal tip a couple of inches within the rectum, the patient lying on the left side with hips elevated, fluid will just naturally run up the descending colon, and then, by a change of position to the right side, the patient will soon feel the gurgling and weight of the fluid in the ascending colon. One quart of any fluid is considered the limit of positive safety in the majority of adults, except, of course, in the presence of contraindications—for example, typhoid fever—and then less is used.

Another thing against which I wish to place myself on record is the Whitehead operation for hemorrhoids. I consider this nothing less than a surgical mutilation, frequently attended with dire consequences. To wear a napkin for the rest of one's days, or to be blessed with an incurable stricture, or an intolerable pruritus, is a poor exchange for a few piles. Conservative methods, scientifically applied, frequently render operative procedures unnecessary. Conservation (excepting the devastating conflict now raging in Europe) is the keynote of the present century.

In closing, let me say, as a general axiom, there are more things in medicine missed by not looking than by not knowing. Observation is half the battle. Bring your diagnosis down to an ocular demonstration whenever possible, and especially in diseases of the rectum.

NATHAN SMITH, NATHAN R. SMITH AND ALAN P. SMITH—A MEDICAL FAMILY.*

By Henry M. Hurd, M.D.

As peculiarly appropriate in a gathering of Baltimore physicians, to whom the name of Nathan R. Smith is a familiar one, I have been asked to give a brief account of the memoir of Nathan Smith recently written by Mrs. Alan P. Smith and published by the Yale Press, and to add some facts in reference to his son, Nathan R. Smith, and his grandson, Alan P. Smith. The memoir as originally written contained sketches of the lives of these three men, and it was hoped that its publication might appeal to the three institutions which were individually interested—the Medical School of Yale University, which Nathan Smith founded; the University of Maryland, where Nathan Ryno Smith, his son, and Alan P. Smith, his grandson, did their life work, and the Johns Hopkins Hospital and University, in both

*Abstract of a paper presented by Dr. H. M. Hurd at the meeting of the Book and Journal Club, January 18, 1916.

of which institutions Alan P. Smith was a faithful trustee and valued adviser. If the work had been properly presented to these three foundations there is every reason to think that it might eventually have been published in this manner; but the celebration of the hundredth anniversary of the founding of the Yale Medical School, in 1914, suggested the wisdom of making an immediate appeal to the Yale Press; and as this proved successful only as far as the volume related to Nathan Smith, it was deemed advisable to limit the publication to his life. The material relating to Nathan R. Smith and Alan P. Smith remains unpublished, but I am not without hope that the friends of the two remaining institutions may undertake its publication jointly.

Nathan Smith came of good English stock, and was born at Rehoboth, Mass., in 1762. His father afterward removed to a farm at Chester, Vt., where Nathan grew up with only the scanty opportunities for an education afforded by a pioneer country. The first record we get of him was his service in the Vermont Militia, when he was called out to protect the inhabitants from the Indians. Later he taught in a district school, and while thus employed he was called upon to assist Dr. Goodhue, a noted Vermont surgeon of the time, in the amputation of a leg. He was so much interested in the operation that he applied to Dr. Goodhue to be taken on as a medical student, but was sensibly advised to go home and study more, or until he was qualified to enter the freshman class at Harvard. He spent a year or more in study with a clergyman at Rockingham, Vt., and at the age of twenty-two went to Dr. Goodhue at Putney, Vt., and remained his office student for the following three years. In 1787—at the age of twenty-five—without any other medical instruction, he went to Cornish, N. H., and established himself in practice. Here he remained two years, and then went to Cambridge, where, in the Harvard Medical School, he attended the lectures of Dr. John Warren in Surgery, Dr. Aaron Dexter in Chemistry and Materia Medica, and Dr. Benjamin Waterhouse in Medicine. In 1790 he received the degree of M.B. With his diploma he returned to Cornish. In 1796—after failing to secure the establishment of a professorship of medicine in connection with Dartmouth College—he arranged to go abroad to study at the University of Edinburgh. He was obliged to exercise the strictest economy in order to make the journey, and even then upon borrowed money. He seems to have been a diligent student in Edinburgh, and after spending three months in London he returned home to Cornish in September, 1797. In the same autumn he delivered a course of lectures at Dartmouth as professor of medicine, although he was not appointed until the following year. In August, 1798, two of his students received the degree of M.B., and the degree of A.M. was at the same time conferred upon himself.

The interest excited by his instruction in this new department

is illustrated by an anecdote related by a gentleman who was an undergraduate in the college:

"President Wheelock came from Dr. Smith's lecture-room to evening prayers in the old chapel, and gave thanks in substance as follows: 'Oh, Lord! we thank Thee for the oxygen gas; we thank Thee for the hydrogen gas; and for all the gases. We thank Thee for the cerebrum; we thank Thee for the cerebellum, and for the medulla oblongata.'"

Before many years a commodious building was erected for the Medical School, which is still in existence. In the year 1812 Dr. Smith decided to go to New Haven to establish a medical school in connection with Yale College. The school opened in October, 1813, with a class of thirty students. In 1820 he became connected with the Medical School at Brunswick, Me., in connection with Bowdoin College, where he delivered various lectures to a class of twenty-one students; but within a few years, we are informed in the Memoir, the class had increased to nearly a hundred. He also, when his son, Dr. Nathan R. Smith, became connected with the Medical School at Burlington, Vt., visited the school and delivered courses of lectures there. Very soon, however, he gave up these outside duties and concentrated his work at New Haven, where he seems to have been extremely successful. He died in 1829.

His remarkable contribution to Medicine was his method of treating typhoid fever by cold affusions. His greatest contribution to Surgery was unquestionably his "Pathology and Treatment of Necrosis." He seems to have published but little, but his writings were always clear and to the point, and his article on typhus (our typhoid) fever can be read to great advantage at the present time.

Dr. Nathan Smith had four sons—David Solon Chase Hall, Nathan Ryno, James Morven and John Derby—all of whom studied Medicine. Nathan Ryno Smith, with whom we are particularly interested, was born in 1797 and spent most of his professional life in Baltimore. He was at first Professor of Surgery at the University of Vermont; later, for two years, Professor of Anatomy at Jefferson Medical College, and then Professor of Surgery at the University of Maryland, with the exception of three years, 1837-1840, when he was Professor of Surgery at Transylvania University. He was pre-eminently a surgeon—noted for his skill, and kindness of heart. He engaged, however, in the general practice of Medicine and was also an oculist. His inaugural thesis at the time of his graduation in Medicine shows much of the modern spirit of medical investigation. He was especially noted in Baltimore for his subcutaneous section of the tendo Achillis, and also for his invention of a lithotome, which he used in two hundred and fifty operations for stone in the bladder; and for his anterior splint. He died in 1877, at the age of eighty years.

Dr. Alan P. Smith, the son of Nathan R. Smith and grandson

of Nathan Smith, was born in 1840 and died in 1898. Although an excellent surgeon, he was also a physician and had a large general practice. He filled for a short time the chair of operative surgery at the University of Maryland. He was one of the incorporators of the Johns Hopkins University and a trustee of the University and Hospital. He was offered the position of surgeon-in-chief of the Johns Hopkins Hospital, but declined it. He was gentle, kind-hearted, sympathetic, and thoroughly interested in all that concerned the improvement of medical education. After a long illness he died at the comparatively early age of fifty-eight years.

A memoir of Nathan R. Smith and of Alan P. Smith should be prepared and published, to do them deserved honor.

ACUTE ABDOMINAL PAIN.*

By Robert Parke Bay, M.D.

In selecting this subject I did not do so with the idea of telling you all about it, for it is something which, if you will agree with me, we all need to keep before us constantly—and then only to find out how little we really know about what is going on within the abdominal cavity. I shall endeavor to emphasize a few practical points which I have observed from my own cases.

As you know, there are about thirty different conditions that may give rise to acute abdominal pain. Someone will no doubt say that, if we will believe what he says, there is no such thing as old-time bellyache; and if I can get you all to believe that when it does exist is in the minority, and should never be diagnosed until the other more dangerous conditions have been eliminated, I will consider it well worth my time. How many of you have seen cases that at first looked typical of acute indigestion—which, however, is only a symptom and not a disease—go on into a general peritonitis, and, if your patient got well was laid up for months probably because you did not go back the next morning, and if you did you never noticed his abdomen, and because his pain was better considered him improved, having ordered a large dose of castor oil or salts on your first visit?

Some of the conditions that cause acute abdominal pain are: First, appendicitis; second, gall bladder diseases; third, perforating ulcer of the stomach or duodenum; fourth, intestinal obstruction; fifth, kidney stones or diseases; sixth, salpingitis; seventh, twisted ovarian cyst; eighth, ectopic pregnancy; ninth, fibroids of the uterus; tenth, adhesions; eleventh, pneumonia.

Of these conditions diseases of the appendix have first place and, according to Dr. Douglas Vander Hoof, thirty-eight per cent.

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*Read before the Kent County Medical Society, Love Point, Md.

of all cases of indigestion are the result of inflammation of the appendix or gall bladder. The first attack of appendicitis, or the first acute pain in the abdomen, the result of appendicitis, starts in the upper abdomen, described by the patient as the pit of the stomach. This is followed by a general abdominal pain, and it is not until from twelve to twenty-four hours that the appendix becomes stuck in the right iliac fossa—and we have localized pain, tenderness, and rigidity over McBurney's point. It will be noticed that this is a movable pain. The first symptoms might very well be symptoms of any of the above conditions, so you can readily see how important the first twelve to twenty-four hours are to your patient; and it is here that history plays such an important part.

I do not feel that nausea, vomiting, diarrhœa, constipation or temperature are of especial importance in arriving at an early diagnosis. The onset, location, duration, character, and history of the pain, along with the pulse and abdominal examination, are far more important. Fever is the most misleading of all the symptoms, as it may be normal or sub-normal in the most serious conditions, especially at the onset.

During the past few months I have had some striking examples of a serious condition being overlooked because the acute abdominal pain was not typical of any one disease. The following examples will illustrate this:

First—Left-sided ectopic pregnancy diagnosed first as acute indigestion and later appendicitis thirty-six hours before operation.

Second—Perforated gastric ulcer of seventy-two hours' duration, not diagnosed because the pain was in the epigastric region and not accompanied by fever or local symptoms until twenty-four hours had elapsed.

Third—Large infected kidney diagnosed appendicitis for the first forty-eight hours before the local symptoms became more pronounced. In this case we had high fever and abdominal distention, with sudden onset of pain.

Fourth—Acute lobar pneumonia referred with diagnosis of acute appendicitis, with pain, fever, muscular rigidity, increased respiration, with physical signs not present for twenty-four hours.

Fifth—Ptomaine poisoning treated for thirty-six hours in several cases and they all entered the hospital with a ruptured appendix and peritonitis.

Sixth—Typhoid fever with enlarged gland frequently starts with acute abdominal pain. On three occasions have I opened the abdomen and removed a mildly inflamed appendix, and the case contained a typical typhoid—and this after all the scientific laboratory findings had confirmed our diagnosis of acute appendicitis.

Seventh—Typhoid perforation diagnosed acute appendicitis. The patient walked into the hospital; was operated upon immedi-

ately; perforation found, and patient made good recovery. The operation took place four hours after the onset of pain.

Eighth—Twisted ovarian cysts. These are very frequent in young women, and in the majority of cases are diagnosed appendicitis from the acute onset and location of pain.

Ninth—Dermoid cysts of the ovary become infected and give rise to acute pain. The pain is frequently referred to the crest of the ilium and down the thigh. One case opened through the sciatic foramen and formed an abcess on the posterior surface of the thigh; diagnosed sciatica.

Tenth—Intestinal obstruction frequently overlooked until it is too late, as the symptoms are not so severe at the onset and seldom accompanied by fever, but always by an irregular distention of the abdomen.

Eleventh—Gastric ulcer overlooked for some months, and patient frequently operated on for gall stones which were not found, only to continue having attacks of pain until perforation took place.

Twelfth—Gall-stones with infected gall-bladder usually recognized, as the acute pain is at the seat of trouble.

In considering these conditions I am endeavoring to show how important it is to make a definite diagnosis in the short time at your disposal, as you know it is necessary to deal promptly with any one of the above conditions. It has been said that every pain has its distinct and pregnant significance if we will but carefully search for it. As Dr. Maurice Richardson has said: "Alone, pain indicates danger in general; in combination with other signs it indicates danger in particular, and guides our hands to its source."

While I believe in all the improved laboratory methods and scientific interpretations of pain, let us not discard the old, well-recognized symptoms—as the coated tongue, pulse-tone and color of the conjunctiva; conditions with which you are familiar, and which should be taught more at the present day.

In conclusion, let me repeat: consider acute abdominal pain as serious until you have proved it otherwise. Do not give cathartics in this condition until you are sure no inflammatory process exists. You may give small enemas, and quiet your peristalsis by ice or heat; give absolutely nothing by mouth, and elevate your patient's head. If you must do something, give Murphy's proctoclysis, and a small dose of morphia (one-twelfth of a grain) may localize your pain. I feel that far more good can be accomplished by lessening the peristalsis than harm by lessening the pain. Always there is danger in delay—and that which ye sow ye shall also reap.

1800 N. Charles Street.

THE TREATMENT OF FRACTURES OF THE LOWER END OF THE TIBIA AND FIBULA.

By Walter D. Wise, M.D., F.A.C.S.

Associate Professor of Surgery, University of Maryland and College of Physicians and Surgeons, Baltimore, Md.

DURING the eight years, 1908-1915, inclusive, Dr. Harrison and the speaker treated in our general work at the office and at Mercy Hospital 1059 fractured bones. Of these, 150 were of the leg and 51 were of the type usually designated Pott's fracture. The habit of describing practically all fractures about the ankle as Pott's fractures has of late years been more or less accepted, and has even found its way into the textbooks. We believe this to be a serious mistake, as it leads to errors of treatment and much misunderstanding.

Our series, more strictly divided, shows 10 fractures of the internal malleolus alone; 16 of the external malleolus alone and 25 cases of true Pott's. These percentages are not at great variance with those of any large series reported, as, for example, the statistics of the Hudson Street Hospital, New York city.

Fractures of the lower end of the fibula alone or of the internal malleolus alone are in most cases rather easily managed, but if either is complicated by a tearing of the opposite lateral ligament or the tibio-fibula ligaments it becomes much more grave, because of the danger of partial dislocation and spreading of the ankle.

The fracture complex described by Percival Pott consisted of a fracture of the fibula in the lower three inches, a rupture of the internal lateral ligament and outward displacement of the foot. The X-ray has shown us that in a large proportion of cases, instead of the internal lateral ligament rupturing, the internal malleolus is pulled off.

A most important part of the pathology, not described by Pott and not mentioned in some standard works, is rupture of the tibio-fibular ligaments, allowing separation of the lower ends of the tibia and fibula, and if not properly treated leading to serious widening of the ankle.

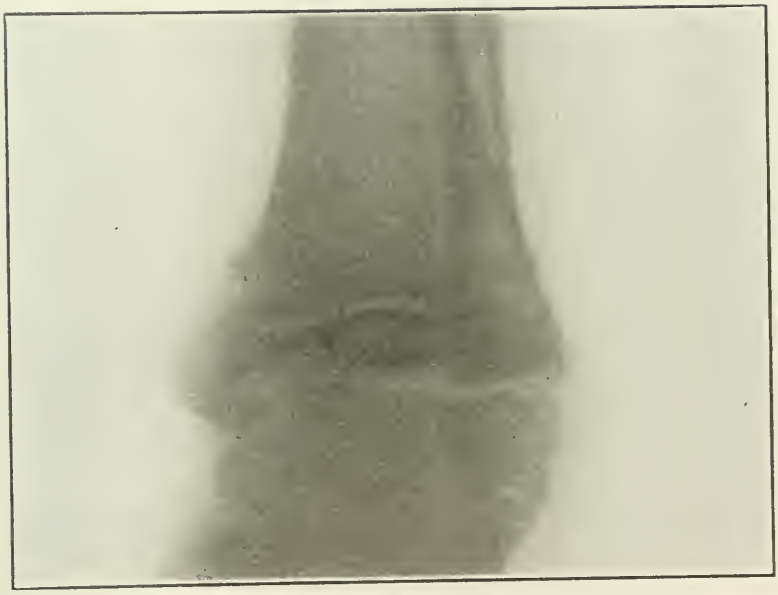
In a true Pott's fracture there is danger of dislocation forward, backward and outward—no danger of the inward variety. In cases where the fibula is broken at the level of the ankle joint and the rest of the pathology is that of a Pott's, there is danger of dislocation in any of the four directions. If there is uncorrected inward dislocation it is perhaps less likely to give spreading of the ankle than is the outward variety, but gives an ugly deformity and considerable disability. If the dislocation is outward and not corrected, it will increase as soon as weight is placed upon the foot and will result in a valgus deformity with flat foot. An uncorrected forward displacement prevents dorsal flexion and the pa-

(1) Showing a moderate amount of anterior displacement associated with an oblique fracture of the tibia and a fracture of the fibula.

(4) Showing a marked posterior displacement of the foot with a large fragment broken from the posterior margin of the articular surface of the tibia.

(3) Showing the fracture and displacement in picture No. 2 reduced.

(4) Showing the anterior posterior view of the fracture in No. 2 after reduction



(5) Shows slight inward displacement due to overcorrection.

(6) Showing the overcorrection of No. 5 corrected.

(7) Showing marked eversion and outward displacement. A line drawn through the middle of the tibia barely catching the inner side of the astragulus.

This patient had had his foot in a cast three weeks and had then been instructed to walk on it—the more the better. In a fracture of this kind weight bearing should be deferred for ten to twelve weeks from the date of injury.

tient can walk only by everting the foot. Posterior displacement also prevents dorsal flexion, because of the tight tendo Achilles.

The object of this paper is to describe in detail a practical unopen method of treating these conditions which is successful in all but a very small percentage of cases. We consider successful those cases which have a good functional result and a minimum of deformity.

When a fracture of the lower end of the leg is first seen, as careful an examination as is possible without giving the patient too much pain is made, and we endeavor to arrive at a definite clinical diagnosis. The fracture is then reduced as accurately as is possible without an anesthetic and with the clinical diagnosis as a guide. A trough splint of firm boards, six or seven inches wide, extending from well above the knee to well below the foot, is then applied. This is thickly padded with common cotton, extra padding being placed above the malleoli, below the knee and wherever else needed to protect eminences and hold the foot in the desired position.

The leg is allowed to remain in this splint five to seven days, during which time antero-posterior and lateral radiographs are made and used as a guide in the reduction (if a further one is necessary) and permanent dressing. At this time the patient is usually anesthetized, and with the X-ray pictures at hand, a careful adjustment is attempted, the procedure varying with the condition one is trying to correct. In a typical Pott's fracture we use inversion and strong adduction, being careful to make inversion of the tarsus, the foot as a whole to be at right angles with the leg. In fracture of the fibula alone the position of the foot should vary with the deformity. If there is little displacement of the fragments, we use slight inversion. If the deformity is a denting in toward the tibia, strong inversion may be needed, and so on. These rules are well known.

The important points to remember are:

1st. Watch lateral displacement inward or outward of the astragalus on the tibia.

2d. Watch anterior or posterior displacement of the astragalus on the tibia.

3d. Keep the tibia and fibula closely approximated.

4th. Keep the foot at right angles to the leg.

To do these things successfully, it is necessary to know the anatomy of the parts in detail, to be familiar with the use of some moldable splint, preferably plaster of Paris, and to have trained assistants.

If there is anterior displacement, it is corrected by strong traction and direct pressure backward.

If there is posterior displacement, it is corrected by strong plantar flexion, followed by a forward pull and dorsal flexion to a right angle.

The reduction of either of the above displacements is made easier by flexion of the knee for the purpose of relaxing the tendo Achilles, and when this measure is not sufficient, it may be neces-

sary to do a subcutaneous tenotomy, as we have had to do in several cases unreduced for a considerable length of time.

The lateral displacement, usually outward, is corrected by adduction of the tarsus, not the metatarsus or phalanges only.

The adjustment is checked up by the appearance of the foot; comparing it with the other, allowing, of course, for swelling, and by careful palpation, which is very important; by freedom of flexion and extension, and later by the X-ray.

After reduction has been obtained, it must be maintained while the cast is being applied, and this is where it is essential to have a trained assistant or at least one who has an understanding of what he is wanted to do.

That reduction and retention can be accomplished in this manner we believe is possible in all but a small percentage of cases. If we can get reduction, we can in nearly all instances maintain it by the judicious use of plaster. The cases requiring nailing have been rare, and those few have been patients referred for bad results of several months or years standing.

The advantages of the unopen method are that there is not the danger, however slight it may be, of infection, and there is not the foreign body to interfere with osteo genesis, as it does in a certain proportion of cases and frequently requiring removal. In the typical Pott's fracture, where the tibio-fibular ligaments are torn, weight bearing should not be allowed for eight to ten weeks, for fear of causing spreading of the ankle joint.

1800 N. Charles Street.

Book Reviews.

THE NOSE, THROAT AND EAR; THEIR FUNCTIONS AND DISEASES. A TREATISE UPON THE BREATH-ROAD, FOOD-ROAD AND ACCESSORY ORGANS. By Ben Clark Gile, M.D., Instructor in Otology in the University of Pennsylvania and Formerly Assistant in the Throat and Nose Dispensary of the University Hospital; Assistant in the Department of the Nose and Throat and Ear and Dispenser Chief at the Presbyterian Hospital; Consulting Laryngologist to the Taylor Hospital and Formerly Instructor in Otology in the Polyclinic Hospital and Post-Graduate School of Medicine, Philadelphia; Fellow of the American Laryngological, Rhinological and Otological Society. With 131 Illustrations, Eight of Which Are Printed in Colors. Philadelphia: P. Blakiston's Son and Company. 1915. Cloth, $2.75 net.

Medicine in all its specialties has made such rapid advances during the past decade that it taxes the specialist to keep up with his specialty; then what is to be expected of the student who is supposed to be more or less of a specialist in every line when he graduates? Undoubtedly his time is so full that it is getting more and more difficult for him to grasp the details of the management

of disorders of the body. And this even despite the great increase in the number of hours which he is now compelled to devote to his studies before being awarded his license to practice. This state of affairs can only be remedied by intensive study of the specialties. The essentials in the diagnosis and treatment should be thoroughly instilled. If the groundwork is assimilated, then it is an easy matter for the student to use a text-book intelligently. Gile has just written a book of this character on diseases of the nose, throat and ear. Within a compass of some 450 pages he has, with brevity, clearness and thoroughness, set forth the essentials of his specialty. Going logically from one subject to another, he has in a connected manner shown the relationship existing between the various nasal and otological maladies. If the student and general practitioner can be educated to recognize the commoner of the nasal maladies, one may rest assured that they will have sufficient judgment to give good, sound advice to their clientele not only in these, but also the rarer remedies. At any rate, they will be sufficiently impressed to refer the case to the proper person for advice. Such a book as the one before us will go a long way to educating the student and general practitioner in good, sound thinking when it pertains to matters affecting the air passages. The author has given us an excellent presentation of the subject, and it gives us great pleasure to recommend the volume to our readers.

The Medical Clinics of Chicago. September, 1915. Volume 1, Number 2. Bi-Monthly. Philadelphia and London: W. B. Saunders Company. Baltimore: The Medical Standard Book Company. Paper, $8 per year.

More and more the profession is coming to learn that more of practical value can be obtained from short, concise articles by representative men, especially when case reports, with the methods of arriving at the diagnosis, are incorporated than from lengthy discourses. With this idea, and based upon these thoughts, Saunders of Philadelphia, ever in the forefront of advancement in American medical literature, are now issuing a bi-monthly incorporating the work of the leaders of the Chicago profession. This number contains reports from the clinics of Isaac A. Abt, William Allen Pusey, Frederick Tice, Walter W. Hamburger, Robert B. Preble, Maurice L. Goodkin, Ralph C. Hamill, Charles Spencer Williamson and Charles Louis Mix, a coterie of men with at least national reputation. Murphy's Clinics have proven so acceptable to the surgical branch of the profession that surely the Medical Clinics should prove an equal boon to the medical. In the present number the publishers have incorporated articles on heart disease in pregnancy, indications for induction of therapeutic abortion and premature labor, cardiac neurosis, psychic effect of heart disease on patient, aricular fibrillation, a case of mitral stenosis and mitral insufficiency in a young girl without subjective symptoms, splenic enlargement, a case of uncomplicated duodenal ulcer (the differ-

ential diagnosis and management), carcinoma of the stomach, tuberculous meningitis, etc. Surely these reports should prove intensely valuable to the internist.

The Starvation Treatment of Diabetes. With a Series of Graduated Diets as used at the Massachusetts General Hospital. By Lewis Webb Hill, M.D., and Rena S. Eckman, Dietitian. With an Introduction by Richard C. Cabot, M.D. Price $1. W. M. Leonard, Publisher.

This book furnishes to the general practitioner in compact form the details of the latest and most successful treatment of diabetes mellitus. It presents the clinical application of the work done in recent years by Dr. Allen at Harvard and the Rockefeller Institute.

This method of treatment, carried out by Dr. Allen at the Rockefeller Hospital, and by the Staff at the Massachusetts General Hospital, has proved very successful. As Dr. Cabot states in the introduction: "It seems already clearly proven that Dr. Allen has notably advanced our ability to combat the disease. * * * To all who wish to give their patients the benefit of this treatment I can heartily recommend this book." In a recent address Dr Allen said: "However specialists may feel, there is no doubt that a majority of average practitioners feel bewildered and helpless concerning diabetes."

To all who have been tried by this baffling disease, this little volume, with its description of treatment, tests and diets, will be of greatest service.

The Limitation of Offspring. By William J. Robinson, M.D., Chief of the Department of Genito-Urinary Diseases and Dermatology, Bronx Hospital and Dispensary; Fellow of the American Medical Association and of the New York Academy of Medicine; Member of the American Urological Association, American Medical Editors' Association, etc.; Editor of The Critic and Guide and of The American Journal of Urology, Venereal and Sexual Diseases; Author of Never Told Tales, Sexual Problems of Today, Practical Eugenics, Sexual Impotence and Other Sexual Disorders in Men and Women, etc. With an introduction by A. Jacobi, M.D., LL.D., Ex-President of the American Medical Association. 1915. New York: Critic and Guide Company. $1 net.

This book incorporates the arguments which Doctor Robinson has been preaching for a number of years concerning the volitional control of pregnancy. He is firmly convinced that there should be better and fewer offspring. He says that there is no more harrowing sight in the home of the very poor, moderately wealthy or wealthy than an undesired pregnancy, which, in the case of the two former classes, often spells financial ruin, and even suicide. He, therefore, has written this book to instruct the laity as to the proper means of preventing conception. His doctrine is this: Under any conditions, and particularly under our present economic conditions,

human beings should be able to control the number of their offspring. They should be able to decide how many children they want to have, and when they want to have them. To accomplish this result he demands that the knowledge of controlling the number of offspring, the knowledge of preventing conception, should not be considered criminal knowledge; that its dissemination should not be considered a criminal offence punishable by hard labor in Federal prisons, but that it should be considered knowledge useful and necessary to the welfare of the race and of the individual, and that is dissemination should be as permissible and as respectable as is the dissemination of any hygienic, sanitary or eugenic knowledge. It is, then, with this aspect of sociological medicine that Doctor Robinson's book deals. Both the pros and the cons are unbiasedly considered. Whatever the personal opinion of our readers, they must admit that it is time, and high time, to find a way to limit the offspring of the epileptic, the confirmed drunkard, the mentally unbalanced, the diseased. Doctor Robinson merely goes a step further—he looks upon poverty as a disease, and as such should be subject to control in the matter of procreation. Whether for or against his theories, the laity and the profession should read the book, which is based upon actual observations made by Doctor Robinson in his daily rounds.

THE CLINICS OF JOHN B. MURPHY, M.D., AT MERCY HOSPITAL, CHICAGO, OCTOBER, 1915. Philadelphia and London: W. B. Saunders Company. Baltimore: The Medical Standard Book Co. A Bi-monthly. Paper, $8 net.

These clinics have become so thoroughly essential to the surgical side of the profession that it is needless to emphasize any longer its merits. As in every one of the preceding issues, so in this, there are a number of articles of genuine interest to the surgeon. This number covers a wide field of general surgery, such as intra-abdominal, bone, joint and thoracic work. It is a mirage of the daily work being done by Dr. Murphy at Mercy Clinic, and is, therefore, practical. If you have not already subscribed to The Clinics, you should.

EMERGENCY SURGERY. By John W. Sluss, A.M., M.D., Associate Professor of Surgery, Indiana University School of Medicine; ex-Superintendent Indianapolis City Hospital; Surgeon to the City Hospital. Third edition, revised and enlarged with 685 illustrations, some of which are printed in colors. Philadelphia: P. Blakiston's Son & Co. Leather, $4 net. 1915.

Sluss is undoubtedly correct when he states the general practitioner of today must be prepared to meet imperative surgery when it arises. With the time now demanded of medical students there is no earthly reason why they should not be reasonably pre-

pared to operate on urgent cases as they arise. He is also right when he says more and more surgery should be done in the home. Certainly this statement applies with great force to those settlements at a distance from large centers of population. What hope is there for a gunshot wound of the abdomen in a patient many hours from a hospital if the local physician is not prepared to operate. So with a number of urgent surgical conditions the local physician should be prepared to operate in case of emergency. If not, his medical education has been sadly imperfect. As a guide to this class in hours of stress, Sluss' Emergency Surgery will be found of incalculable value. It covers, and covers well, most of the surgical conditions which demand immediate attention. The only criticism which we feel constrained to make is that many would-be surgeons in reading its pages will be deluded into believing that intricate surgical therapeusis is easy, and thus attempt to do something for which they are entirely unprepared, as the book is so well written that it leaves the impression all surgery is easy. However, for those who are reasonably prepared, it is an admirable guide.

The Principles and Practice of Obstetrics. By Joseph B. De Lee, A.M., M.D., Professor of Obstetrics at the Northwestern University Medical School; Obstetrician to the Chicago Lying-in Hospital and Dispensary, and to Wesley and Mercy Hospitals; Consulting Obstetrician to Cook County and Provident Hospitals, etc. 938 Illustrations. 175 in Colors. Second Edition, Thoroughly Revised. Philadelphia and London: W. B. Saunders Company. Baltimore: The Medical Standard Book Co. 1915. Cloth, $8 net.

De Lee's obstetrics represents the last word in book-making. Without doubt, taken all in all, it is the best obstetrics on the market. Magnificently illustrated, well printed, and of easy diction, the reader can ask no more. Without anything else, the illustrations would make the book, but when this feature is added to the beautiful diction, one naturally becomes enchanted with the book. No words can describe its virtues. It is so absolutely complete and is one of the best exponents of the bookmakers' art that it has been our pleasure to see in many a day. Anybody desirous of purchasing a complete reference book will find it here. And as in so many books, one will not hear the complaint that the purchaser is disappointed. If he is, nothing can satisfy him. Here from alpha to omega the entire art and science of midwifery, from the beginning of conception to the management of the puerperium, is faithfully reproduced. The anatomy, the physiology, the diagnosis, the management of pregnancy are one and all plainly expounded. Both the theoretical and practical sides of obstetrics are thoroughly treated. We could not criticise if we would, as there is not a vulnerable point. It has our utmost praise. Nothing is then left for us but to give it our heartiest endorsement and recommendation, as we know it will please.

MARYLAND MEDICAL JOURNAL

NATHAN WINSLOW, M.D., *Editor*

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RICHARD H. JOHNSTON, M.D.

BALTIMORE, MARCH, 1916

THE STARVATION TREATMENT OF DIABETES.

OF the important contributions to recent medical progress, none is more interesting to the internist or holds out more promise of relief to suffering humanity than the starvation treatment of diabetes as inaugurated and practiced by Dr. Frederick M. Allen of the Rockefeller Institute Hospital. If the results of this treatment as furnished by Lewis Webb Hill, together with a series of graduated diets as used in the Massachusetts General Hospital are as successful in the hands of others, a distinct advance has been made in the therapeutics of diabetes mellitus. The plan of treatment is simplicity itself. As it has been employed with so much success at the Massachusetts General Hospital, it cannot help but be of more than passing interest to our readers. To insure success, the physician must think in grams of carbohydrate and proteid. It is not enough to cut down the supply of starchy foods, he must know exactly how much carbohydrate and proteid food the patient is receiving each day. As practiced at the Massachusetts General Hospital, the details are as follows:

For 48 hours after admission the patient is kept on ordinary diet, in order to determine the severity of his diabetes. Then he is put to bed, and no food allowed, except whiskey and black coffee. The water intake need not be restricted. The whiskey is given in the coffee, one ounce of whiskey every two hours from 7 A. M. to 7 P. M. This diet furnishes roughly about 800 calories. Sodium bicarbonate, two drachms every three hours, may be given if there is evidence of acidosis, as indicated by a strong acetone or diacetic acid reaction in the urine. In most cases this

has been found unnecessary. Those who have practiced this severe reduction in diet have noticed no evidence of impending coma. Heretofore a severe reduction in diet in diabetics was looked upon askance and was dreaded as the possible precursor of coma. Therefore this observation, that diabetics will tolerate starvation without ill-effects is most important. The patient is kept in bed and on the above diet until he is sugar free, the sugar usually disappearing from the urine in two to three days; seldom does it take longer. Dr. Hill states the patients withstand starvation remarkably well, and in no case has he seen bad results from it. As soon as the patient is sugar free he is allowed to get up and is placed upon a diet of vegetables containing 5 per cent. carbohydrate. A moderate amount of fat in the way of butter can be given with this diet if desired. The first day after starvation the carbohydrate intake should not be over 18 grams. Then, according to the behavior of the patient, the proteid, fat and carbohydrate diet is gradually raised, always bearing in mind that an excess of proteid is an important factor in causing glycosuria. If sugar appears in the urine during the raising process, drop back to a simpler diet. If this proves unavailing, repeat the starvation process and raise the diet more slowly. The author definitely states if the diet is raised very slowly, sugar will not reappear. If the patient is taking a fair diet and is doing well without any glycosuria, it is not desirable to raise the diet any higher than proteid 50, carbohydrate 50 and fat 200 grams. The essential points brought out by Allen are:

It is not dangerous to starve a diabetic, and two or three days of starvation almost always make a patient sugar free.

After starvation the diet must be raised very slowly.

An excess of proteid must be regarded as capable of producing glycosuria.

It is not desirable for all diabetics to hold their weight.

Although this treatment has only been in existence slightly over two years, it apparently has yielded those who have tried it far superior results than the old methods of treating diabetes mellitus. It is yet too early to forecast the permanent effect of such a diet, but it does appear that a substantial advance in the treatment of diabetes has been made, and we give it to our readers for a trial.

Medical Items.

Two former members of the staff of Johns Hopkins Hospital have been decorated by Germany for their services in the Medical Corps of the German Army. Dr. Karl H. Van Noorden, Jr., who was attached to the medical staff at the Hopkins, was decorated with the iron cross of the second class after the battle of Lodz, in which he was shot through the hip; and Dr. Felix Landois, who was also on the surgical staff, now surgeon-in-chief and organizer of a field hospital at Ledeghen, Belgium. He was decorated with the Order of Frederick and with the iron cross of the second class, bestowed by the King of Wurttemberg.

Dr. Joseph I. France of Port Deposit and Baltimore has announced his candidacy for the nomination for United States Senator.

Dr. William H. Bash, in charge of the accident ward of Mercy Hospital, Baltimore, has resigned, to take effect in May. He will practice in West Virginia. Dr. H. Hayward Johnson, an interne, has been appointed to succeed Dr. Bash.

Dr. Roy D. McClure of the resident staff of Johns Hopkins Hospital has accepted the position of surgeon-in-chief of the Henry Ford Hospital, Detroit.

Smallpox has again broken out in Hagerstown, six cases having been reported, four of which patients have practically recovered. Dr. C. W. G. Rohrer, assistant chief of the Bureau of Communicable Diseases of the State Board of Health, has been to Hagerstown and investigated every reported case. It is thought the disease was brought to Hagerstown from Roanoke, Va.

The articles of merger between the College of Physicians and Surgeons and the University of Maryland were ratified by the regents of the University January 5, and by this act the combination between these schools becomes a legal fact. The members of the faculty of the College of Physicians and Surgeons who were taken into the board of regents of the university are as follows: Drs. John W. Chambers, Harry Friedenwald, Archibald C. Harrison, Standish McCleary, William F. Lockwood, William S. Gardner, Cary B. Gamble, Jr., and George W. Corner.

A bill providing for an appropriation of $10,000 for the erection of a hospital in Charles county, to be known as the Southern Maryland Emergency Hospital, has been introduced in the General Assembly. The bill provides for an additional appropriation of $3000 a year for maintenance, and provides also that the $10,000 appropriation is not to become available until the directors of the institution certify that an additional $5000 has become available, either through private donations or by levy made by the county commissioners, or both.

Dr. Thomas M. Stewart announces his association with Drs. John W. Murphy and Martin H. Urner and his removal to their offices and private hospital, suite 2711 Union Central Building, Fourth and Vine streets, Cincinnati, Ohio.

Dr. Hugh H. Young, who has been convalescing at Johns Hopkins Hospital for some days from illness, spent a few days at Atlantic City after leaving the hospital. He was accompanied by Mrs. Young.

The Ladies' Board of the West End Maternity Hospital held a linen shower and reception at the hospital, 112 North Calhoun street, on February 22, for the benefit of the free wards.

The Ladies' Auxiliary of the Board of St. Agnes' Hospital gave a benefit theater performance and dance on February 21 at the Academy of Music.

Dr. William H. Welch has been elected president of the University Club of Baltimore, Md.

ENGAGEMENT

The engagement is announced of Dr. Clifford Clinton Hartman, Johns Hopkins Medical School, '11, of Pittsburgh, Pa., to Miss Carlotta Barnes Bailey of Churchville, Md. Dr. Hartman is a member of the medical staff of the Allegheny General Hospital, Pittsburgh, Pa.

MARRIAGES.

Dawson L. Farber, M.D., Baltimore Medical College, '13, to Miss Jean Cowan Ennis, both of Baltimore, Md., at Rockville, Md., September 9, 1915. They will reside in Magnolia, O., where Dr. Farber will practice.

Russell H. Dean, M.D., University of Maryland Medical School, '12, to Miss Esther F.

Haile, both of Jacksonville, Fla., at Jacksonville, December 10, 1915. They will reside at 305 Cedar street, Jacksonville.

Rollin B. Page, M.D., Maryland Medical College, '05, of Baltimore, Md., to Miss Grace Ball of Easton, Md., at Dennison, Ohio., February 5, 1916. After a wedding trip spent in the West, Dr. and Mrs. Page will reside in Baltimore.

DEATHS.

Thomas H. Shearer, M.D., Homeopathic College of Pennsylvania, '58, of 905 N. Charles street, Baltimore, Md., died at his home from an impacted fracture of the neck of the thigh bone, February 18, 1916, aged 90 years.

Jocelyn William Blackmer, M.D., University of Maryland Medical School, '15, of Salisbury, N. C., died at his home in that town February 1, 1916, aged 28 years. Dr. Blackmer was formerly on the staff of the Springfield Hospital at Sykesville, Md.

James McHenry Howard, M.D., University of Maryland Medical School, '69, of Baltimore, Md., died at the Johns Hopkins Hospital, after a lingering illness, January 31, 1916, aged 77 years.

Joseph Aloysius Mudd, M.D., University of Maryland Medical School, '64; a member of the Medical Society of the District of Columbia in 1865; assistant surgeon in the Confederate Army and author of a book recording his war observations and experiences with Porter in Northern Missouri; died at his home in Hyattsville, Md., January 21, 1916, from acute dilatation of the heart, aged 73 years.

Andrew B. Mitchell, M.D., University of Maryland Medical School, '66, died at the Home for Incurables, Washington, D. C., January 20, 1916, from myocarditis, aged 75 years.

Charles Farquhar, M.D., of Olney, Md., died at his home February 1, 1916, aged 75 years.

George Dwight Kahlo, M.D., Bellevue Hospital Medical College, New York, '91; medical director of the new baths at the Greenbrier White Sulphur Springs, W. Va., and a former lecturer at the Johns Hopkins University, died at Old Point Comfort, Va., February 12, 1916, aged 50 years.

James J. Durrett, M.D., University of Maryland Medical School, '97, a member of the West Virginia State Medical Association, who had been ill as the result of a nervous breakdown, died at his home in Fairmont, W. Va., January 10, 1916, from the effects of a gunshot wound of the head, self-inflicted, it is believed, with suicidal intent, aged 43 years.

John Gilbert Spangler, M.D., College of Physicians and Surgeons, '87; a member of the Medical Society of the State of Pennsylvania; of Mapleton Depot, Pa., while going over the Pennsylvania system of Mapleton, January 7, 1916, was struck by a train and killed instantly, aged 55 years.

Henry M. Jewett, M.D., College of Physicians and Surgeons, '88, formerly attending surgeon to the Roger Williams' Eye, Ear and Throat Infirmary, Providence, R. I., and a practitioner of Providence, died at his home in Edgewood, Providence, January 10, 1916, aged 56 years.

Norvel H. Baker, M.D., Baltimore Medical College, '82, formerly a practitioner and druggist of Gillette, Wyo., died in Sheridan, Wyo., January 10, 1916, aged 59 years.

Frederick Lawford, M.D., University of Maryland Medical School, '00; a member of the Medical Society of Virginia; surgeon to the Norfolk and Southern Railway and Berkley Street Railway; proprietor of the Lawford Hotel and Hospital, Berkley, Norfolk, Va., died at his home in Norfolk, January 24, 1916, from pneumonia, aged 40 years.

William G. Bradshaw, M.D., College of Physicians and Surgeons, '81; postmaster of High Point, N. C.; a druggist, banker and furniture manufacturer; died at his home, January 19, 1916, from cerebral hemorrhage, aged 60 years.

Charles L. Wachter, M.D., College of Physicians and Surgeons, '84, of Sabillasville, Md.; member of the Frederick County School Board until a month ago; director of the Thurmont Bank, died at Sabillasville, February 4, 1916, aged 60 years.

William Edward Moseley, M.D., Harvard Medical School, '74, F. A. C. S., of 614 North Howard street, Baltimore, Md., died at his residence February 10, 1916, aged 67 years.

ABSTRACTS.

ARE WE EXAGGERATING THE DANGERS OF HIGH PRESSURE?

(*Critic and Guide*, November, 1914.)

By Tom A. Williams, M.B., C.M., Edin.,
Washington, D. C.,
Neurologist to Epiphany and Freedmen's Hospitals; Corres. Mem. Soc. de Neurol. et Psych., Paris, etc.

High arterial tension is not itself a great danger, but the agent which produces it is. The author attributes it to hyperproteosis, and the cause of this is the failure of the organism to deal with an excess of protein. Cases are reported showing the efficacy of treatment which limits the proteins and increases the metabolism by proper dietary means. Not all the cases show arterio-sclerosis, or high blood pressure. Vertigo paresthesia, lumbago, recurrent headache or a thick, dull feeling, with incapacity to concentrate, or wakefulness and irritability, or melancholy, may be the chief signs. Alcohol is of little importance in the etiology, except in cases where it produces hepatic or renal insufficiency. Any pressure above 120 is abnormal, even though usual in older people. Anxiety and strain are merely subsidiary factors.

REMARKS ON INTRATHECAL INJECTIONS AS A FACTOR IN THE IMPROVEMENT OF TABETICS AFTER SALVARSAN.

(*The Alienist and Neurologist*, November, 1914.)

By Tom A. Williams, M.B., C.M., Edin.,
Washington, D. C.,
Neurologist to Freedmen's and Epiphany Hospitals; Corres. Mem. Soc. de Neurol. et Psychiat., Paris, etc.

Both on clinical and laboratory grounds the adequacy of intravenous injections of salvarsan, followed by mercury intravenously, intramuscularly or even by inunction, is maintained. Of the author's 60 cases, two especially striking are reported.

A man tabetic for six years has been functionally well for two years, with a reduction of cell count from 38 to 9 after three courses of salvarsan and mercury, totalling six intravenous injections in all. A woman who had been treated for six years for rheumatism, at Clifton Springs and other places, showed great loss of weight and strength, marked ataxia, almost complete loss of pain, vibration and attitude sense of the lower limbs, as well as loss of the tendon and pupil reflexes. She was recommended salvarsan and mercury, against the opposition of several physicians. Seen only a few weeks ago, this patient, although she has had only four periods of treatment of two salvarsans and from four to six weeks of mercurial injections in each, she is perfectly well, of normal weight, save for the lost reflexes and a

slight sensory loss in the tibial border of the feet, and can work with enjoyment again.

As no arsenic is demonstrable in the serum used for intrathecal injection, and arsenic is found in the serum after intravenous injection, and as no improvement has followed intrathecal injection unless intravenous injection is employed also, it should be obvious enough that the intravenous injection is the more important procedure. The clinical facts of Sachs and the author show this. The anatomical facts should leave one to infer it; for the disease process, although a meningitis, is deep in the membrane and is chiefly around the vessels, which are nourished not from the cerebro-spinal fluid, but from the blood. Any benefit attributable to intrathecal injections must be due to their topical effect in causing hyperaemia. These considerations show that the method is not specific, and in view of the numerous relapses its superiority is doubtful.

1705 N Street.

OBJECTIVE PSYCHOLOGY.

Adolf Meyer, Baltimore (*Journal A. M. A.*, Sept. 4, 1915), remarks on the confusion and lack of agreement in the minds of medical students and teachers as regards the relations of psychology to physiology and pathology. The difficulty lies, he says, in the hesitance to accept a frankly biologic view of the reactions and behavior of man. As soon as mental attitudes and mental activities are accepted as definite functions of a living organism, mentation and behavior is treated as a real chapter of the natural history of man and animal and psychology ceases to be a puzzle, supposedly resisting the objective methods in science. The difficulty will be largely relieved. He specially endeavors to make plain, he says, what is meant by the fundamental assertion that what is important to us is as observable and objective as any other fact of natural history, that is, what is of importance to us is the activity and behavior of the total organism or individual as opposed to the activity of single organs. Each individual has his own mental activity, and to say we cannot see it and make it accessible and understand it in others is a philosopher's scare like the claim that we can never know whether the world exists because we know only mental states or processes. Common sense has never worried about the reality of the world, and the first step in a course of psychology for medical students is to restore in them the courage of common sense. The first condition, Meyer says, for productive work in this field of psychobiology, as in any other, is controlled procedure and methods of description and record and experimentation which come up to definite standards.

COLLICULECTOMY.

A. G. Rytina, Baltiomre (*Journal A. M. A.*, Jan. 2, 1915), describes his technic of the operation for the removal of the verumontanum, which can be performed, he claims, with less risk of subsequent complication than the use of the cautery and the application of strong silver nitrate commonly used. The descrip-

tion of the technic requires the illustrations to make it perfectly clear. The operation is radical, he says, and, in allowing the removal of the almost intact verumontanum, enables us to make accurate pathologic studies with the result that a more rational interpretation of the symptomatology and therapy may be anticipated. Of course, the operation should only be carried out in specially selected cases. He describes the anatomy and histology of the parts and of the sinus pocularis, which his studies show is a long canal lined by a many-layered, squamous epithelium ending in the substance of the vermontanum by a complicated system of invaginated processes. The structure is clearly favorable for retention products, and suggests difficulty in eradicating infection, which is the sole cause, as far as seen by him, of pathologic conditions of the verumontanum. His conclusions are as follows: "1. Colliculectomy is a simple operation for removal of the verumontanum. It is less liable to untoward complications and sequelae than strong applications of silver nitrate or the thermocautery. 2. The study of the pathology of the verumontanum is made easy, in consequence of which a therapy will be devised that will be based on science, rather than on empiricism. 3. Surface applications of mild antiseptic solutions seem to be rational. Strong penetrative cauterant substances may have great therapeutic value in curing infections, but may do more harm than good, on account of the production of untoward complications or sequelae. 4. A straight-beaked colliculectome lends itself to removal of vegetation and polypi from any part of the anterior urethra." The article is illustrated.

DISEASES OF THE EPIDIDYMIS AND TESTICLE.*

By Henry H. Morton, M.D.,
Brooklyn, N. Y.,
Clinical Professor of Genito-urinary Diseases, Long Island College Hospital; Genito-urinary Surgeon, Long Island College and Kings County Hospitals and the Polhemus Memorial Clinic, etc.

Epididymitis is more frequently seen than orchitis. Causes are gonorrhea, traumatism, passage of urethral instruments, or as a sequel to prostatectomy. The organisms reach the epididymis through the vas deferens by means of its peristaltic action, which moves in either direction.

Causes of orchitis are syphilis, malignant disease or metastasis during an attack of mumps.

Gonorrheal Epididymitis—Testicle red, swollen, tender, inflamed. The epididymis is enormously swollen, and surrounds the testicle. A small quantity of hydrocele fluid is usually found. Discharge from urethra usually ceases while epididymis is affected and begins again as the inflammation subsides.

Treatment. Preventive—Have patient wear suspensory and keep as quiet as possible. No urethral instruments should be passed and no forced injections given.

When present the patient should be put to bed, the scrotum supported with a handkerchief bandage, and continuous hot applica-

*Abstract of Clinical Lecture given in the Long Island College Hospital and reprinted from the *New York Medical Journal for February* 13, 1915.

tions applied. Hot flaxseed poultices or hot lead and opium work very well.

Cold is no longer used, as it is liable to leave a hard, tough infiltration of the epididymis, thereby causing sterility.

In moderately severe cases, accompanied with great pain, 20 per cent. guaiacol ointment covered with cotton and heat usually allays the suffering.

In recurring epididymitis or in very severe cases which do not respond to treatment, the Hagner operation is indicated.

Where there is a great deal of hydrocele fluid present, aspiration of the fluid makes the patient comfortable.

Where the epididymis has been blocked as the result of inflammation and the patient sterile, the patent end of the epididymis may be transplanted into the testicle and a new channel for the exit of the spermatoza is made. In about 50 per cent. of cases operated the sterility is relieved.

Tuberculosis of the Epididymis—Begins as a small, painless lump, which gradually increases in size.

The epididymis is usually infected:

1. By hematogenous infection.
2. By extension from higher up; vesicles, prostate, kidneys.

Later the testicle becomes infected, and breaks down and becomes filled with pus.

The focus may remain latent for a long time and then be lighted up by some traumatism.

Treatment—Epididymectomy is the operation of choice when the testicle is not involved, but when the testicle is affected castration is indicated.

After the patient recovers from his operation he should be instructed to lead an out-of-door life, as ordered in the case of any other tuberculous individual.

ABSTRACT OF CLINICAL LECTURE ON STRICTURE OF THE URETHRA GIVEN IN THE LONG ISLAND COLLEGE HOSPITAL AND REPORTED IN THE MEDICAL TIMES.

By Henry H. Morton, M.D., F.A.C.S.,

Brooklyn, N. Y.

Clinical Professor of Genito-urinary Diseases, Long Island College Hospital; Genito-urinary Surgeon, Long Island College and King's County Hospitals, and the Polhemus Memorial Clinic, etc.

Case I—Male, 45; sailor. Gonorrhea many years ago. External urethrotomy for stricture 10 years ago. No sounds passed after operation. Second external urethrotomy eight years ago. Passed bougie on himself for six months. Admitted to hospital for acute retention with bladder distended to umbilicus. Whalebone guide could not be introduced, so suprapubic puncture was done, and subsequently external urethrotomy without a guide.

Case II—Boy, 16; U. S. Seven years ago ruptured urethra by jumping into milk can. Eight operations have been performed, last one two years ago. Sounds passed every week for one year.

On admittance it was found that a filiform guide was all that

would pass through stricture. Tunnelled sounds could not be passed because of density of stricture. Operation would probably leave a permanent perineal fistula. Theatment by continuous dilatation was decided upon.

The filiform guide was left in place for 48 hours, then a small flexible bougie could be passed. This was left in place for 48 hours, and then a larger size passed and left in the canal. Now the patient wears a 20 flexible bougie. Sounds will be passed from this time till stricture is well dilated.

The urine is voided around the bougie in the urethra.

Remarks on subject of retention of urine:

In retention of urine, bladder is filled, but patient is not able to empty it.

In suppression of urine, no urine is secreted by kidneys.

In rupture of bladder a catheter is introduced into bladder, and little or no urine obtained. A measured quantity of fluid is introduced into bladder, but full amount does not return, as it has leaked out into peritoneal cavity.

Causes of retention of urine are:

1. Stricture, which may be spasmodic or organic.

2. Enlargement of prostate due to senile hypertrophy or gonorrheal inflammation.

3. Foreign body impacted into urethra, such as a calculus, or something introduced for purposes of masturbation.

4. Paralysis of bladder, in acute fevers or due to nervous disorders.

Examination reveals a round, smooth, fluctuating suprapubic tumor, due to percussion. Rectal examination should be made to determine condition of prostate and urethra explored with a steel sound.

Treatment—A spasmodic stricture and oftentimes an organic stricture will respond to a full dose of morphia and a hot sitz bath prolonged for half an hour, but the main dependence in cases of retention is the catheter. In many cases where a catheter cannot be passed a filiform whalebone guide will enter the bladder and a Gouleys tunneled catheter used. Adrenalin solution, because of its property of shrinking the mucous membrane, is sometimes of value, and then the urethra should be distended by filling with olive oil.

After bladder is emptied guide is left in place and stricture is treated either by operation or continuous dilatation.

In cases where a guide will not pass stricture suprapubic puncture or the operation of external urethrotomy must be resorted to.

In cases of retention due to gonorrheal prostatitis urethra should be well irrigated before catheter is passed, so as to lessen chances of infecting bladder. In senile hypertrophy of prostate a catheter should be inserted at once. The bladder should not be emptied entirely in these cases, as it may cause urosepsis and suppression of urine.

Foreign bodies may sometimes be removed with a long urethral forceps through endoscope, but usually a perineal or suprapubic operation is called for.

Publishers' Department.

Danger Due to Substitution.

HARDLY another of all the preparations in existence offers a wider scope to imposition under the plea of "just as good" than the scientifically standardized Eucalyptol.

The most recent fraud practiced in regard to this product is an attempt to profit by the renown of the firm of Sander & Sons. In order to foist upon the unwary a crude oil, that had proved injurious upon application, the firm name of Sander & Sons is illicitly appropriated, the make-up of their goods imitated, and finally the medical reports commenting on the merits of their excellent preparation are made use of to give the desired luster to the intended deceit.

This fraud, which was exposed at an action tried before the Supreme Court of Victoria at Melbourne, and others reported before in the medical literature, show that every physician should see that his patient gets exactly what he prescribed. No "just as good" allowed.

K-Y.

ASK any doctor point blank the antidote for opium, or arsenic, or strychnine, and his answer would be prompt and practical.

But ask him the antidote for physiological friction, and he might hesitate before the word lubrication came to mind.

Nevertheless, lubrication is a word that should suggest much to the doctor, for he needs lubrication—and not only lubrication, but perfect lubrication—every time he uses the catheter, sound, speculum, scope, the examining finger or any instrument of penetration.

Hence Friction's Antidote should suggest K-Y Lubricating Jelly. Nay, more, it should persuade or compel him to have at hand, in his bag and on the shelf, a tube of "K-Y," which is insurance against trouble or annoyance.

K-Y Lubricating Jelly is a perfect lubricant. It is greaseless and water-soluble, which means that it is efficient and convenient. Its essential property is slipperyness and it is not sticky. Neither does it stain the skin or soil the clothing. It is emollient and protective. It is transparent and economical to use.

Consequently it is not only of service for lubricating instruments of penetration, but it serves as an effective dressing or application to burns and scalds. When applied early, taking care to cover all of the affected surface,

it often prevents blistering. It relieves the soreness of chafes and promotes healing.

It soothes pruritus even of the most severe kind in many cases, and is useful in dermatitis, urticaria, eczema, irritable ulcers, etc.

One especially valuable use for K-Y Lubricating Jelly is to anoint the skin in scarletina, measles, chickenpox, etc. It protects, allays irritation, and can be used without soiling or staining the clothing of the patient.

K-Y Lubricating Jelly also keeps the surgeon's hands supple, protects against bichloride rash and "protects the feel."

Friction physiologically considered is a thing to be avoided. Its proper antidote is lubrication. The correct form of lubrication calls for slipperyness which is not supplied by grease or oil. Furthermore, grease or oil is unpleasant to use and it leaves behind stains or soiled places on the patient's linen, etc.

Instruments of penetration—such as the sound, catheter, speculum, scope or the examining finger—must be lubricated and so perfectly lubricated as to slip easily. To pass such an instrument deftly, quickly, with a minimum of pain or discomfort to the patient, requires perfect lubrication, which, in turn, enhances the manual dexterity and deftness of the operator. Patients are growing to be increasingly critical. They note their physician's attention to the "little things" and judge accordingly. Hence, anything that will add to his skill or deftness must appeal to the doctor, and for that reason he must be interested in K-Y Lubricating Jelly—Friction's Antidote.

This preparation is slippery but not sticky. It is greaseless. It is water-soluble. It is transparent. It is non-irritating. It is convenient to use and economical.

Properties which will recommend it to the discriminating doctor who has his patient's best interests as well as his own at heart. K-Y Lubricating Jelly is also a valuable emollient and protective agent in burns, scalds, bed sores, chafes, dermatitis, urticaria, hives, etc.

It relieves pruritus in the majority of instances, and is exceedingly useful as a soothing and protecting application to the skin of children suffering from scarlet fever, measles, chickenpox, etc.

K-Y Lubricating Jelly also keeps the surgeon's hands smooth, prevents bichloride rash and "improves the feel."

Physiological Friction is of double disadvantage. To the patient it brings discomfort, pain and sometimes severe suffering. It sometimes causes the doctor to lose some of his usual

deftness and thus impresses his patient that he is careless or not as skilled in manipulation as he might or ought to be.

And Physiological Friction is further to be regretted because it is so easily avoidable in most instances.

A skidding sound hurts, but when well lubricated with K-Y Lubricating Jelly, which is Friction's Antidote, it slips securely along its accustomed or intended track.

A dragging rectal or stomach tube strains the patient's forbearance and often makes the dread of repetition so strong as to postpone or abandon subsequent calls.

An examining finger hurts—unless perfectly lubricated, and the word perfectly does not admit of grease or oily substances.

For grease is not an ideal agent for this purpose; it soils the patient's clothing, prejudices the doctor's reputation for consideration, and marks the user as being unprogressive and careless.

K-Y Lubricating Jelly *is* Friction's Antidote.

Because K-Y Lubricating Jelly is slippery—not sticky—and therefore easily adapted for lubricating instruments of penetration.

It is greaseless and water-soluble, not only clean and easy to apply, but non-soiling and removable by even cold water without soap.

The very properties that render K-Y Lubricating Jelly a perfect lubricant make it emollient and protective.

Furthermore, K-Y Lubricating Jelly is to a striking degree *soothing*. Applied after a burn or a "chafe" it relieves promptly and hastens healing.

In pruritus—even in severe forms of genital, anal, diabetic, eczematous itching—K-Y Lubricating Jelly will, in a great majority of cases, bring relief, or at least grateful alleviation.

To anoint the skin in scarlet fever, measles, chickenpox, K-Y Lubricating Jelly is not only effective, but convenient and economical, since it can be used without staining or soiling the bed clothes or the patient's linen.

One use in particular will appeal to the surgeon—K-Y Lubrication Jelly makes the hands soft and supple, prevents bichloride rashes and "improves the feel."

Before and After Childbirth.

Childbirth is always attended by more or less danger and discomfort. Too often the extra burden a prospective mother has to bear overtaxes her nutrition and strength.

The mother who nurses her baby also frequently has to have supportive treatment to enable her to meet the demand placed on her bodily metabolism by the needs of her growing offspring. At such times of stress effective tonic treatment is always required, and clinical experience has clearly shown that no remedy is so serviceable from every standpoint as Gray's Glycerine Tonic Comp.

Used throughout the later months of pregnancy and during the puerperium, it gives to the mother the exact stimulus and support needed not only to carry her through a trying period but to fit her for the still more exacting one of lactation.

Free from contraindication, it is the one remedy that the practitioner can employ before and after parturition with absolute certainty that its effects will never be harmful but invariably beneficial and helpful.

An Alterative of Long Service.

It is mainly in chronic skin and glandular diseases that alteratives have found their most distinct field of usefulness, for these are conditions aggravated and continued by impaired nutrition and elimination, in the correction of which alteratives show what potent remedial forces they are. Among the alteratives IODIA (Battle) has long enjoyed professional favor and in this will be found a striking demonstration of its value, for no class of drugs are put to a more rigid test than alteratives, so its long-continued use by physicians is the best evidence that it meets the demands made upon it. IODIA (Battle) will show its power in chronic skin diseases, glandular involvements and in other states indicating the corrective influence of an alterative agent. A distinct advantage offered by IODIA is that it may be continued over long periods without causing distress.

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There are numerous silver salts on the market. One of the most efficacious of these is believed to be the proteid-silver compound manufactured by Parke, Davis & Co. under the name of Silvol. This product occurs in scale form, has a dark, lustrous appearance, and contains about 20 per cent. of metallic silver. Silvol is slightly hygroscopic, consequently is readily soluble in water. Aqueous solutions of any strength desired may be prepared from Silvol—solutions having this important advantage: They are not precipitated by proteids or alkalis or any of the reagents that commonly affect other silver compounds in solution. More-

over, Silvol solutions do not coagulate albumin or precipitate the chlorides when applied to living tissue.

The use of Silvol is indicated in inflammatory affections of mucous membranes generally. It may be used locally in solutions as strong as 40 per cent. without producing pain or irritation. In acute gonorrhea, as an abortive measure, a 20 per cent. solution may be injected every three hours, while in the routine treatment the injection of a 5 per cent. solution three times a day is recommended.

Silvol penetrates tissue and destroys pathogenic bacteria. It is non-toxic. The product is available in two forms—powder (ounce bottles) and capsules (6-grain), bottles of 50. The contents of two capsules make one-fourth ounce of 10 per cent. solution. For application to regions where the use of an aqueous antiseptic solution is impracticable, Silvol Ointment (5 per cent.) has been devised. This ointment is marketed in collapsible tubes (two sizes) with elongated nozzle.

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WHILE the course and progress of acute lobar pneumonia is short, sharp and decisive, the impression made upon the general vitality is often profound, and apparently out of proportion to the duration of the disease. Even the robust, theiric patient is likely to emerge from the defervescent period with an embarrassed heart and general prostration. In such cases the convalescent should be closely watched and the heart and general vitality should be strengthened and supported, and this is especially true as applied to the patient who was more or less devitalized before the invasion of the disease. For the purpose indicated, strychnia is a veritable prop upon which the embarrassed heart and circulation can lean for strength and support. As a general revitalizing agent is also needed at this time, it is an excellent plan to order Pepto-Mangan (Gude), to which should be added the appropriate dose of strychnia, according to age, condition and indications. As a general tonic and bracer to the circulation, nervous system and the organism generally this combination cannot be surpassed.

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References

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DR. HENRY M. HURD, Baltimore. DR. NATHAN R. GORTER, Baltimore. DR. J. ALLISON HODGES, Richmond, Va.
DR. THOS. A. ASHBY, Baltimore. DR. SAMUEL C. CHEW, Baltimore. DR. WM. F. DREWRY, Petersburg, Va.
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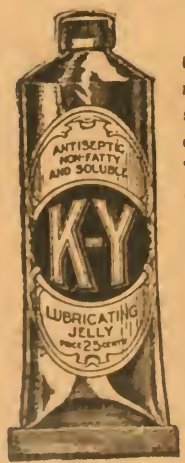

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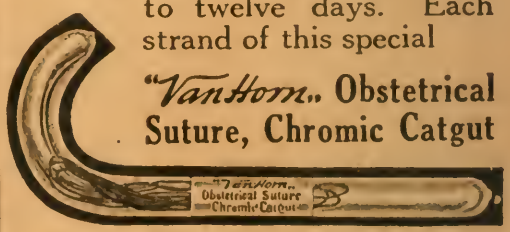

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